

TABLE OF CONTENTS.

	Page
1. Organization of the Program in Cooperation with Medical and Allied Professions and Lay organizations.	1
2. Administration of the Program	1
a. A Division of Venereal Disease Control.	1
b. Direction by a Venereal Disease Control Officer	1
c. Duties of Venereal Disease Control Officer.	2
d. Auxilliary Personnel in The Division of Venereal Disease Control	3
3. Treatment Services.	3
a. General Principles.	3
4. Definition of Beneficiary of Public Clinic Service.	4
5. Definition of Physical Quality of Clinic Service.	4
6. Clinic Conduct.	4
7. Clinic Personnel.	5
8. Clinic Equipment.	5
9. Hospital Services	6
10. Gonorrhea	6
a. Diagnosis	6
b. Treatment of Gonorrhea.	7
c. Tests of Cure	8
11. Syphilis.	8
a. Diagnosis	8
(1) Primary Syphilis	8
(2) Secondary Syphilis	9
(3) Latent Syphilis.	10
(4) Syphilis and Pregnancy	10
(5) Congenital Syphilis.	10
(6) Late Syphilis.	11
b. Management of Syphilis.	11
c. Treatment of Primary, Secondary, or Latent Syphilis	12
12. Chancroid	14

	Page
13. Lymphogranuloma Venereum.	16
14. Granuloma Inguinale	17
15. Case-Holding and Case-Finding	19
a. General Considerations.	19
b. Case-Holding.	20
c. Case-Finding.	20
16. Information and Education	21
a. Professional.	21
b. Public.	22
c. Patient Education	23
17. The Charlatan, and The Unethical Pharmacist and Physician	23
18. Prostitution.	24
19. Classification of the Venereal Diseases	28
20. Community Venereal Disease Control Councils	29
21. Suggested Clinic Monthly Report Form.	30

THE PRINCIPLES OF VENEREAL DISEASE CONTROL

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500

June 1947

1. Organization of the Program in Cooperation with Medical and Allied Professions and Lay Organizations.

In the organization of a national venereal disease control program for Japan, careful attention should be given to the part to be played by the medical and allied professions and lay organizations. Although the Ministry, with the direction and supervision of the Public Health and Welfare Section, SCAP, must determine the scope and define the content of the program and administer many of the details, the private practitioner, the local and prefectural medical societies, the hospital, nursing, welfare and voluntary public health agencies, the public schools, medical schools, and a variety of other agencies, will have specific duties to perform in the actual application of many of the control procedures. Unless they are informed as to the Ministry's plan and are in general sympathy with its principles, they will either fail to assist to the full extent of their capacities or, in ignorance of the aims of the control program, may work at cross purposes to the eventual detriment of the public welfare.

Interested, active, and well-informed voluntary organizations can be of invaluable assistance in securing public support for the program, and in extending the health department's channels of the public information and education. It is doubtless to the disadvantage of many prefectural programs that not enough attention is paid to this matter of public relations.

Organizations of the general public, that is, non-professional groups, are very important in the last analysis. The greatest stimulus to the reluctant or uninspired public health worker is the persistent demand and continuous interest of the people he is paid to serve.

2. Administration of the Program

a. A Division of Venereal Disease Control. Venereal disease control should be a function of a separate section in the prefectural health department. In Japan venereal diseases are too outstanding a problem to be grouped with other infectious diseases. Where it is impracticable to make venereal diseases control a separate section, it should be the function of a subsection, with a high degree of autonomy, in the section of communicable disease control or its equivalent.

b. Direction by a Venereal Disease Control Officer. Whether there is a section or a sub-section of venereal disease control, the program should be directed by a venereal diseases control officer who gives his entire time to the duties

of his office. This officer should be the best trained clinically, should be amenable to further training, and should have the best knowledge of modern venereal disease control methods.

c. The duties of the venereal disease control officer should include as a minimum the following:

(1) The definition of the aims, purposes, and policies of the venereal disease control program. Since it will be his responsibility to carry out the program, under the direction and supervision of the Military Government Health Officer, he should administer that part of it with which the section of venereal disease control is directly involved; that is, he should have administrative supervision over all of the work of the section and over all of its personnel.

(2) The collection and analysis of morbidity data. Future planning, the need for more personnel, supplies, equipment and financial aid are all dependent upon the gathering and presentation of accurate statistics. As the extent and prevalence of venereal disease become recognized, additional facilities will be easier to acquire. It is important that the venereal disease control officer keep himself informed, through the study of statistics, as to the results of the program and as to any progress which is being made toward the control of the venereal diseases. The actual collection and analysis of all morbidity data are the function of a section of vital statistics in the health departments. In such cases, however, the venereal disease control officer should be permitted to prescribe the data to be collected for his purposes, and the scope of their analyses. He should have the fullest cooperation of the section of vital statistics in the planning and conduct of special studies, particularly as they pertain to analyses of treatment, case-finding and case-holding performance of clinics and other treatment sources. Certain statistical data must be available to the prefectural V.D.C.O. each month, so that he can submit his monthly report of Venereal Disease Control Activities to the V.D.C.O. in the Ministry.

(3) The establishment of effective cooperation with physicians in private practice, through conferences with local medical societies, provision of consultation services, by the health bureau clinics distribution of effective and helpful medical literature, provision of prefectural laboratory services and such other assistance as will lead to the willing participation of physicians in the health bureau's program.

(4) The development of cordial relations not only with the public but with special scientific groups. He should conduct a continuous campaign of sound public education in venereal disease control. He should be the liaison officer between the health bureau and the several agencies which will share in the development of the program.

(5) Administrative consultation to other units within the health bureau, such as the sections of laboratories, maternal and child health, anti-tuberculosis. He should have considerable voice in the determination of what emphasis is to be placed upon those parts of the program which may be administered by these sections in order that one service may not overbalance the other, and in order that one section may not work at cross-purposes with another to the embarrassment of both and to the confusion of the public.

(6) The organization and supervision of venereal disease clinics. The health bureau should conduct sufficient in-patient and out-patient facilities to adequately serve the population of the prefecture. The prefectural V.D.C.O. must either conduct these clinics personally, or supervise the work of the clinicians who are operating the clinics. Methods used should be as approved by the Military Government Health Officer and the Public Health & Welfare Section of SCAP.

(7) The organization and supervision of epidemiologic and followup services for clinics and private physicians.

(8) Study and control of the efficiency of venereal disease clinics in terms of contact tracing, efficacious treatment, and case holding.

d. Auxiliary Personnel in the Section of Venereal Disease Control. The venereal disease control officer should be supported by such administrative assistants, professional consultants, case-holding and case-finding personnel, and clerical staff as the execution of the program may demand. To whatever extent the program can be expanded from time to time, more nearly to approach the ideal, the staff of the section should be increased to permit the effective execution of the expanded program.

3. Treatment Services

a. General Principles

(1) The provision of adequate public treatment services is a basic necessity for venereal disease control in Japan. As has been demonstrated in other countries, the level of venereal disease control work is raised in direct proportion to the number of public facilities available. It is a matter of readily verified fact that most of the infected who seek treatment at public clinics are either on relief or are managing a precarious independent existence. Many are young people with small earning capacities, if they work at all. It is not likely that many patients in Japan at this time are seeking free care at public agencies in spite of being able to pay for private care. The treatment of the venereal diseases, and especially of syphilis, is time consuming and, at private practitioners' rates, is expensive. Those of the infected who can afford long continued medical care at the hands of private physicians will not often be found in public clinics where the danger of recognition is great, where long periods of waiting are the rule, where mass methods may leave little room for close patient-physician relationships, and where a multitude of other embarrassments and inconveniences must too often be tolerated. The more talk that is heard as to who will pay for the patients care, the poorer the medical care will be.

(2) The venereal diseases are communicable diseases. The right of the community to protect itself against exposure to communicable disease is recognized wherever there is civilization. In providing public treatment for the indigent infected with venereal disease, the community exercises a prerogative consistent with this right to protect itself. It is only in the public clinic that the large mass of the economically handicapped can be given efficient service at a price which the community can afford to pay. The provision of adequate treatment is vastly more than the simple introduction of medication into the patient. Consultation, case-holding and case-finding services are important functions of venereal disease control which could hardly be provided for the great number of the medically indigent in any other way than through organized clinic services.

4. Definition of Beneficiary of Public Clinic Service.

Diagnostic and treatment facilities should be provided for:

a. The diagnosis and emergency treatment of all persons who apply. All contagious patients must be considered a community hazard and treated until non-communicable.

b. All patients referred by private physicians either for continued treatment or for consultation.

c. All patients unable to pay for private medical care.

5. Definition of Physical Quality of Clinic Service.

Clinics should be so located as to be easy of access and of maximum convenience to the population of the areas which they are to serve. The number of clinic sessions should be such as to meet the needs of the area without overcrowding or unreasonable delay. Night sessions should be held if necessary and at such hours as to prevent loss of time from work to employed patients. Special attention should be paid to special conditions, such as advanced pregnancy, the need of a patient to catch a bus, to return to work, or to return to children left at home.

Health Bureau Clinics should be held in clean, well-lighted, well-ventilated rooms, so located and arranged as to offer adequate privacy but not to imply isolation (as of a communicable disease), nor segregation (as of undesirable people). The physical arrangements should be such as to insure privacy in history-taking, physical examination and treatment, to provide adequate waiting-room and toilet facilities, and to contribute to the self-respect of the patient. In other words, the accessibility and the physical character of the clinic should be such as to invite and encourage regularity of attendance; not to discourage it or to imply that any treatment at all, no matter how disreputable the environment in which it is administered, is good enough for the venereally infected.

Children are preferably handled in a family clinic with the late afternoon or Saturday morning hours. Their mothers should be treated for their venereal infections during these same sessions, and prenatal and pediatric care when necessary should also be available in these family clinics.

6. Conduct of Clinics

a. Clinic sessions and hours should be well publicized. Patients should be examined in the order in which they appear at the clinic, although exceptions may be made for a very sick patient, mothers with several small children, or a working person with only a short time off from his job. The other patients who were not taken in turn should understand why another patient was seen ahead of them.

b. The general atmosphere of the clinic is of major importance and should be felt the moment the patient enters. All patients should be treated with courtesy; professional dignity must never be violated, and a friendly, business-like attitude should prevail in which the patient feels a respect toward the physician and nurse in their professional capacities.

c. A sincere interest in each patient and a kindly manner should be maintained regardless of the patient's economic, social position, educational level, or personal appearance. Public health venereal disease clinics treat patients in such a way that the majority of patients are very desirous of carrying out every medical or epidemiologic directive given to them by the clinician or the nurse.

d. Good manners are a first requirement in a professional service dealing with the public. A display of haste, loud voices, and impersonal handling of patients such as is common in prostitute hospitals should not be tolerated for the general public. Remarks should be directed to the person concerned and not to the entire clinic. Irrelevant conversation should never be indulged in during clinic hours. Food should never be prepared or eaten in the clinic.

e. Modern venereal disease clinics in health centers are noted for their cleanliness, quietness, efficiency and gentle handling of patients. In a public health venereal disease clinic patients should be made to feel welcome. In these respects the clinic nurse has the main responsibility. By her deportment, bearing, and kind reception of each patient, the nurse sets the tone of the entire clinic.

f. The most important public health teaching is done while the patient is in the clinic. Every patient will respond to a clear explanation of his particular case with more enthusiastic cooperation. The tactful handling of each patient and careful instruction while in the clinic are most effective in case control and eliminate the necessity for much correspondence and home visits.

7. Clinic Personnel

a. All clinic personnel should be technically qualified for the particular functions which they must perform.

b. Minimal clinic personnel should consist of (1) a qualified physician who is a graduate of a recognized medical school, who has had at least 6 months of special training under supervision, in the management of the venereal diseases, and who has a tactful and sympathetic personality and a particular interest in the venereal diseases and their relation to the public health; (2) a qualified technical nurse who should assist the physician in the technical aspects of clinic operation, the routing of patients through the clinic, the entry of clinical notes of a routine nature, etc; and (3) a clerk, (female), who should keep clinic records and statistics, attend to the clerical aspects of the follow-up system, and attend to the clinic correspondence. To this fixed minimum of intramural personnel there should be added such assistants in all of the categories as may be necessary to the efficient, and effective operation of the clinic without undue waste of the patients' time and case-holding and case-finding personnel as may be adequate to the problem with which the clinic is confronted.

8. Clinic Equipment

a. Clinic equipment should be adequate to the proper and efficient handling of the patient, his adequate physical examination, and his competent treatment. Adequate facilities should be available for the collection of specimens for examination in the laboratory and in the clinic for the immediate examination of smears, chancre serum (by dark-field), urine, unless adequate laboratory service is available close at hand. Lack of dark-field substages in many prefectures will necessitate sending capillary tube specimens of serum from suspected chancres to the nearest laboratory having a dark-field microscope.

b. History, physical examination and treatment record. Clinic records should provide for recording the patient's medical history, the results of an adequate physical examination, treatments given, reactions to treatment, tests for cure, and the condition of the patient at the time of any interruption of his connection with the clinic whether because of cure, the further need for treatment, transfer to treatment elsewhere, or unauthorized discontinuance of treatment. The record should provide, further, for recording the identity of all of the patient's contacts and the result of their follow-up.

9. Hospital Services

a. Hospitalization should be provided, at the discretion of the clinic chief, for patients with open lesions of early syphilis under certain circumstances, particularly in case of infectious relapse or for the recalcitrant or promiscuous patient, or when there are unusual home or social conditions. It should also be provided for lumbar puncture if this service cannot properly be provided in the clinic, or when there are circumstances which make it advisable to have the patient under hospital control.

b. Only those hospitals should be used that belong to the national, prefectural, or municipal governments. Hospitals that are partially or totally controlled by private or special interests should not be used by the health bureaus.

10. Gonorrhea

a. Diagnosis

(1) In the Male:

(a) Cultural evidence of the presence of the gonococcus is adequate, in itself, for the diagnosis of a gonococcal infection. Cultural evidence is defined as including those fermentation tests which differentiate between the gonococcus and other members of the groups of gram-negative diplococci which resemble the gonococcus.

(b) A diagnosis of gonorrhea may also be made in the male, under the following three conditions:

1 If intracellular, gram-negative diplococci which resemble the gonococcus are found in smears from the male genito-urinary tract, and if the history of the infection or the clinical evidence is presumptive of gonococcal infection.

2 If extracellular organisms are found in typical clusters during the earliest hours of an acute infection, and the history or clinical findings are presumptive of gonorrhea, clinical diagnosis of gonorrhea may be made and the case treated as such. Smears should be made at frequent intervals thereafter as intracellular organisms may be found at a later date (especially in a case which does not respond to sulfonamide therapy).

3 A clinical diagnosis should be made in the presence of a suggestive history and suspicious clinical findings, confirmatory laboratory findings being lacking, and the patient treated as if he had gonorrhea. Repeated search should be made for the gonococcus thereafter, however.

(3) The patient may improve clinically under this regime and laboratory reports may appear to be negative, but unless the clinician is satisfied that the patient is cured, it is better to wait three days and then repeat the course of the drug.

(4) Sulfonamides should not be given intravenously. Vaccines should not be used. Douches, washing, and irrigation apparatus should be removed from the clinics and not used in the future. They are of no value in the treatment of gonorrhea. They may do harm. Topical applications are useless. Modern treatment is systemic and by chemo-therapy. The clinician's time is too valuable to waste in useless procedures which do not "keep the patient clean", and which have no medical value.

c. Tests of Cure:

(1) Three negative cultures obtained at 48 hour (or weekly) intervals plus a negative culture obtained after a menstrual period are satisfactory evidences of cure in the female. The longer the observation period, the better. The patient is examined several times during a three-month period. If all tests are negative during this period, the patient may be considered cured.

(2) If cultures are not available, reliance must be placed on smears. The clinician should remember that in the diagnosis of chronic gonorrhea, especially in women, smears are notoriously unreliable. Laboratory samples must be obtained carefully from secretion expressed from Skene's, Bartholin's, and the endocervical glands. The gonococcus will not be found on the surface of the mucous membranes.

(3) Patients treated for gonorrhea, especially those treated with penicillin, should receive a serologic test for syphilis once a week for a month, and once a month for the next three months. The possibility of masking primary syphilis with penicillin used in the treatment of gonorrhea should be kept in mind.

11. Syphilis

a. Diagnosis

(1) Primary Syphilis

(a) Any genital sore in male or female is possible primary syphilis until proved to be otherwise.

(b) Any indolent lesion anywhere on the body (especially lips, tonsils, fingers) which fails to heal in two weeks may be primary syphilis.

(c) The diagnosis of primary syphilis is a laboratory, not a clinical procedure.

(d) Suspected primary syphilis should not be treated locally until repeated dark-fields are negative.

(e) Antisyphilitic treatment must not be given on suspicion alone. The diagnosis must be proven. Once treatment is begun, it must be carried through until 40 arsenicals and at least 30 heavy metals have been given.

count!

(f) There is reason for urgent hast in diagnosis; hours

(g) The diagnostic procedures are as follows:

1 Dark-field of surface serum; if negative, repeat at least three times on consecutive days before local treatment.

2 If surface dark-field is negative, do dark-field of aspirated serum from lesion's base, or, dark-field of aspirated material from the regional lymph node.

3 If you have no dark-field microscope, send the patient at once to someone who has; or send a capillary tube specimen to the nearest laboratory that has a dark-field substage.

4 Do serologic test on all patients with open lesion at first visit. If any of these tests are positive, treat at once. If all are negative --

5 Do serologic test follow-up for 3 months, weekly for first month, every 2 weeks thereafter.

(h) No physician who has not actually had training and experience in the recognition of *Spirochaeta pallida* should attempt the diagnosis of syphilis by the dark-field; too many serious errors are likely to be made. This is especially true of lesions in the mouth where organisms resembling *Spirochaeta pallida* are frequently found. A diagnosis of syphilis made by dark-field from preparations taken from the mouth, should never be made.

(2) Secondary Syphilis:

(a) Do blood serologic follow-up (3 months) on any lesion which was possibly primary syphilis.

(b) For any generalized skin eruption - DO A SEROLOGIC TEST.

(c) For any sore mouth or throat which does not heal in 10 days - DO A SEROLOGIC TEST.

(d) For any unexplained patchy loss of hair - DO A SEROLOGIC TEST.

(e) For any iritis or neuroretinitis - DO A SEROLOGIC TEST.

(f) For any vague bone pains or polyarticular arthralgia -- "acute, subacute, or chronic infectious arthritis" - DO A SEROLOGIC TEST.

(g) Lift the top from a papular lesion and examine the serum by dark-field. It is highly desirable to recognize the approach of the open, infectious stage of secondary syphilis before it develops--hence, the serologic follow-up advised is maxim #1. The next five maxims call attention to the five common manifestations of secondary syphilis--generalized skin eruptions, mucosal lesions, alopecia, iritis and arthralgia, although others, much less common, do occur. Ninety-five percent of all patients with secondary syphilis will present

one or a combination of these five manifestations. Unfortunately, the lesions of secondary syphilis may either be completely lacking or so trivial and evanescent as to be overlooked by patient and physician alike. Further, unless blood tests are made, the fact that the lesions are due to syphilis may be entirely missed, and some other diagnosis made.

(h) Fortunately, the properly performed serologic test has its highest negative value during the secondary stage of syphilis. It is always positive (100 percent). If it is negative, there is practical assurance that the patient has some other disease. On the other hand, it must be remembered that a patient may have a positive blood test as the result of an old infection with syphilis, and at the same time have any one of the above signs or symptoms as the result of concurrent condition, not syphilis. The history of exposure or the history of a primary lesion may help to settle the question.

(3) Latent Syphilis: All syphilitic infections are latent at some time, and most of the time until ultimate break-down occurs. There is no way to recognize latent syphilis except by serologic tests.

(4) Syphilis and Pregnancy:

(a) Few syphilitic pregnant women have lesions, and history and physical examination are nearly worthless as aids in making the diagnosis in this group. The diagnosis can be made in most cases only by serologic tests. Every pregnant woman should have at least one and preferably two serologic tests for syphilis during pregnancy. One test should be taken during the early months of pregnancy and another about the seventh or eighth month.

(b) If proper treatment is begun before the 16th week of pregnancy, the infected mother can be assured of a baby free from syphilis in almost every case. Treatment must be adequate and continuous throughout pregnancy, and should be continued to completion. A careful history for any reactions to the previous treatment must be elicited before each succeeding treatment. Urine specimens should be checked frequently for signs of renal damage.

(c) Pregnancy usually causes the signs and symptoms of syphilis to become less obvious. Most pregnant women with syphilis are unaware of the disease and have no signs or symptoms. Treatment is almost always well tolerated and the clinician will not encounter any special trouble if the reaction to each previous treatment is carefully noted.

(5) Congenital Syphilis:

(a) Syphilis should be suspected in every baby of a known syphilitic mother, whether or not she was treated before or during pregnancy.

(b) Syphilis should be suspected in puny, ill-nourished, wizened infants who "won't gain", in infants with skin rashes of any type, in those with snuffles or those with "pseudoparalysis".

(c) In older children, syphilis should be suspected if there is "pink eye" (it may be interstitial keratitis), deafness unless clearly middle ear, hydrarthrosis of the knees (Clutton's joints), osteomyelitis, and peculiar second dentition. Check suspicion by serologic test of both child and other members of its family.

(d) If the facilities are available, make a dark-field examination of scrapings from the wall of the umbilical vein. The finding of *Spirochaeta pallida* establishes the diagnosis at the earliest possible moment.

(e) If quantitative serologic tests can be made, do quantitative serologic tests on the cord blood and on the infant's blood at 1, 2, 4, 6, 8, and 12 weeks of life and at intervals thereafter for at least the first 2 years. If the child does not have syphilis, the titer will decrease and usually become negative before the end of 8 or 12 weeks. If the child has syphilis, the titer may rise, or it may fall at first and then rise.

(f) If titration cannot be done, it may be assumed that a positive serologic test of the infant's blood after 8 weeks to 3 months means syphilis. If the test is negative at 3 months, it should be repeated at 6 months, 1 year, and 2 years. If all these tests remain negative, the child certainly has escaped infection with syphilis.

(g) Roentgenograms of the infant's long bones at the age of 2 weeks may establish the diagnosis if there is characteristic evidence of syphilitic osteochondritis at the epiphyseal lines. Negative findings do not exclude the possibility of syphilis. Interpretation of the roentgenograms must be made by an experienced roentgenologist, since deposits of bismuth (if the mother has been treated with bismuth) may make differential diagnosis difficult.

(6) Late Syphilis:

(a) Late syphilis may attack any part of the body. Its manifestations are so numerous and its differential diagnosis so difficult, clinically, that it has well earned the name of "Great Imitator". It is impossible, outside of a voluminous textbook, to discuss the diagnosis of late syphilis adequately.

5. Management of Syphilis

(1) General Principles: In general, no treatment should be given until the diagnosis is made either by dark-field or confirmed by serologic tests. No therapeutic tests should be used. If, under the pressure of a most unusual and extreme emergency, treatment for a lesion suspected of being a chancre must be begun before laboratory confirmation of the diagnosis can be obtained, (or if treatment has been begun elsewhere without adequate diagnosis), such treatment should conform fully to the scheme for early syphilis and must be carried through to completion as if a positive diagnosis of syphilis had been made.

(2) Where adequate supplies of penicillin are available, syphilis is now treated in Rapid Treatment Centers. For a period of less than two weeks the patient is hospitalized and given combined treatment with mapharsen, bismuth and penicillin. Various amounts of these drugs are used but at least 5 injections of mapharsen, 3 injections of bismuth and 2,000,000 units of penicillin are given during the patient's period of hospitalization. The penicillin is given in divided doses, every 3 hours night and day until the entire amount has been given. As can be seen, this regime necessitates adequate supplies of penicillin, sufficient in-patient facilities, and trained nursing and medical personnel. Where this treatment regime can be instituted the follow-up problem on lapsed cases is nil. In Japan, at this time, it is obvious that Rapid Treatment Centers are not feasible.

In some instances, such as patients who are pregnant and too near term to institute the usual treatment regime, it may be possible to hospitalize the expectant mother and institute treatment with penicillin, mapharsen, and bismuth. However, most patients at the present time will have to be treated with mapharsen and bismuth according to the schedule given in this manual.

(3) Treatment should be begun with an arsenical in early and latent syphilis but with bismuth in cardiovascular syphilis and certain forms of central nervous syphilis. The preferred arsenical, outside of clinics with well-trained medical personnel, is arsenoxide (mapharsen). Under expert direction, arsphenamine or other arsenicals may be employed. The preferred bismuth preparation is bismuth subsalicylate in oil.

(4) Each treatment should be recorded upon the patient's clinic record, including the date, form of drug, dose given, and any reaction noted.

(5) It cannot be too strongly emphasized that clocklike calendar regularity of treatment without long or short variation or lapses, is critically important both to control of infectiousness and cure. Every effort should be made to impress this fact upon all of the clinic personnel on every occasion.

(6) Emphasis should be placed upon the need for the completion, by each patient, of the full treatment schedule in the time called for by the type of infection which he presents. The results of serologic tests should not be permitted to interfere with this schedule of treatment. "Treatment to noninfectiousness" only, should never be accepted as the objective of any clinic in any case.

(7) The infectiousness of syphilis is not to be predicted upon the results of blood tests but upon the total time, course, laboratory tests, physical inspection, and treatment summation of the case.

c. Treatment of Primary, Secondary or Latent Syphilis

(1) All patients started on treatment will receive the full course of 40 arsenicals and at least 30 bismuth injections.

(2) A negative serologic test for syphilis (STS) will not be used as a reason for stopping treatment before 40 arsenicals and 30 heavy metals have been given.

(3) Any patient who becomes delinquent before receiving 20 arsenicals and 20 bismuth injections must be considered infectious and must be returned to treatment according to the directive SCAPIN 153 which classifies venereal diseases with other communicable diseases.

(4) If old arsphenamine is used, the dosage will be 0.3 grams and will be given only once a week.

(5) If neoarsphenamine is used, the dosage will be 0.45 grams, and will be given only once a week.

(6) Mapharsen is an arsenical drug that has been used in place of Arsphenamine (Salvarsan) and Neoarsphenamine (Neosalvarsan). It is less toxic than the other arsenicals and is just as effective even when given in one-tenth the amount of Neoarsphenamine.

(7) It must be thoroughly aerated when it is mixed, and it should be injected into the vein quickly in twenty seconds or less.

(8) If Mapharsen and Bismuth Subsaliolate are used, the following schedule will be adhered to:

Week Mapharsen 0.04 gms to 0.06 gms. TWICE a week. Bismuth Subsaliolate 0.2 gms (1 $\frac{1}{2}$ cc) intramuscularly once a week

1	"	"	"	"	"	"	"
2	"	"	"	"	"	"	"
3	"	"	"	"	"	"	"
4	"	"	"	"	"	"	"
5	"	"	"	"	"	"	"
6	"	"	"	"	"	Onit Bismuth	
7	"	"	"	"	"	"	"
8	"	"	"	"	"	"	"
9	"	"	"	"	"	"	"
10	"	"	"	"	"	"	"
11	Omit Mapharsen		Bismuth Subsaliolate	0.2 gms.	ONCE	a week	
12	"	"	"	"	"	"	"
13	"	"	"	"	"	"	"
14	"	"	"	"	"	"	"
15	"	"	"	"	"	"	"
16	Mapharsen 0.04 gms to 0.06 gms.		<u>Twice</u>	a week.		Onit Bismuth	
17	"	"	"	"	"	"	"
18	"	"	"	"	"	"	"
19	"	"	"	"	"	"	"
20	"	"	"	"	"	"	"
21	Mapharsen 0.04 gms to 0.06 gms.		Twice	a week.		Bismuth Subsaliolate 0.2 gms.	
22	"	"	"	"	"	intramuscularly <u>once</u>	a week.
23	"	"	"	"	"	"	"
24	"	"	"	"	"	"	"
25	"	"	"	"	"	"	"
26						"	"
27						"	"
28						"	"
29						"	"
30						"	"
31						"	"
32						"	"
33						"	"
34						"	"
35						"	"
36						"	"
37						"	"
38						"	"
39						"	"
40						"	"

Total Treatment: 40 Arsenicals, 30 heavy metals.

Recheck the blood test every 3 months for the first year after treatment, every six months the second year and at yearly intervals thereafter.

An examination of the spinal fluid should be made within the first 6 months following treatment.

If the blood test, after having been negative becomes positive and stays positive, (in the absences of other causes such as acute infectious diseases, vaccinations, immunizations), the patient should be retreated.

(9) Treatment in late latent syphilis should begin with a series of injections of bismuth subsalicylate. Thereafter, arsenicals and bismuth are given in alternate courses at weekly intervals. Example: Bismuth for 10 weeks, arsenicals for 10 weeks and repeat until 30 arsenicals and 40 injections of bismuth have been given.

(10) The treatment of LATE Syphilis must be individualized according to the existing type of organic pathology.

12. Chancroid

a. Definition

(1) Chancroid (soft chancre) is a localized venereal disease caused by the *Hemophilus ducreyi*, transmitted only by direct contact, and characterized by painful single or multiple genital ulcers, often complicated by suppurating inguinal bubo. The incubation period is usually 2 to 5 days, but may be longer.

b. Epidemiology

(1) The disease occurs primarily among peoples that live on a low hygienic level. There are undoubtedly symptomless carriers, usually female.

c. Course

(1) The disease begins as a vesicopustule which breaks down rapidly. The pustule soon ruptures, leaving a sharply circumscribed, shallow ulceration. The edges may become ragged and undermined. The base is moist and covered with necrotic, grayish exudate. When this is removed, an uneven base of purulent granulation tissue is revealed. The lesion is surrounded by erythema and is usually very painful. Multiple lesions may develop rapidly by auto-inoculation. Induration is usually absent in untreated lesions, but boggy induration may be present if local treatment has been applied.

(2) The lesions occur in the following sites in order of frequency: in the male-prepuce, frenum, shaft, anus; in the female-labia, clitoris, fourchette vestibule, anus, and cervix. Spread by auto-inoculation may take place anywhere in the perigenital zone.

(3) Regional adenitis frequently develops within a few days to 2 weeks. The bubo is usually large, unilateral, soft, fluctuant, acutely inflamed, and tender. Untreated, it has a tendency to rupture at a single point. However, it may subside without suppuration when the patient is treated with sulfonamides.

(4) Phimosis and paraphimosis may occur. There is a tendency to spontaneous healing, both of genital lesions and of bubo, with scar formation. Systemic reactions are mild or absent.

d. Diagnosis

(1) All patients with penile ulcers of any description should be admitted to a hospital for diagnosis and treatment. If this is not practicable the physician must be sure that the patient understands and will observe isolation technique.

(2) Since primary syphilis may clinically resemble chancroid, and since mixed infections of these two diseases may occur (the chancre appearing in the chancroid), the diagnosis of syphilis must be confirmed or ruled out by laboratory tests.

(3) A blood serologic test for syphilis should be made on admission, repeated once a week for the first month, and at monthly intervals for 3 months, unless a diagnosis of syphilis is established earlier.

(4) The diagnosis of chancroid may be aided by the laboratory examination of stained smears from the lesion, or by culture of pus from the lesion or the bubo.

e. Treatment

(1) Chemotherapy

(a) Systemic. Sulfadiazine or sulfathiazole should be administered in all cases. One gram four times a day until the lesion is healed is recommended. Where adequate hospital service is available, the drug is given every four hours, night and day for one week.

(b) Local. Nothing but cleanliness (soap and water) is necessary. Keep the ulcers clean and dry.

(2) Surgical Treatment

(a) The bubo should never be incised. If fluctuation is present, aseptic aspiration with a 16-gauge needle is recommended; this may be repeated if necessary. Sulfadiazine ointment should be applied to the puncture wound.

(b) Marked phimosis or paraphimosis may be treated by immersion and soaking in hot magnesium sulfate or saline solutions during systemic sulfonamid therapy. Circumcision or dorsal slit is undesirable and is rarely necessary.

f. Prophylaxis

(1) Personal cleanliness is important.

(2) Caution: All patients receiving sulfonamides should consume at least 3000cc of fluid daily.

13. Lymphogranuloma Venereum

a. Definition

(1) Lymphogranuloma venereum (also known as lymphogranuloma inguinale, 4th venereal disease, Nicholas-Favres Disease, lymphopathia venereum, and by numerous other names) is a systemic virus disease, acquired venereally, and characterized by a small evanescent herpetiform initial lesion frequently followed by regional lymphangitis and adenitis.

b. Epidemiology

(1) The disease is generally acquired through sex contact. The existence of asymptomatic carriers is suggested by the numerous individuals with positive Frei tests without clinical signs or symptoms of the disease.

c. Course

(1) The disease usually begins as a trivial and transitory, painless, small erosion, papule, or herpetiform vesicle or ulcer, of the penis, vulva, vagina, peri-anal area, or anal or rectal canal which frequently escapes the patient's notice.

(2) The invasion of the lymph nodes usually occurs from 10 to 30 days after infection. Inguinal adenitis is often bilateral and occasionally subsides without suppuration. During this stage, constitutional symptoms (prostration, malaise, fever, meningitis, meningo-encephalitis, or other bizarre manifestations) may be observed. The lymph nodes may fuse to the skin. Multiple areas of softening occur in the matted nodes followed by break-down and the development of numerous sinuses. Extensive scarring accompanies healing. The anorectal syndrome is more frequently found in the female and is characterized by rectal pain, discharge of blood and pus from the anus, a tendency toward extreme chronicity, and the production of rectal strictures.

d. Diagnosis

(1) A positive Frei reaction cannot be relied upon absolutely to establish the lymphogranulomatous nature of any clinical condition, since it is known that, in untreated infections with lymphogranuloma venereum, skin sensitivity persists for many years, probably for a lifetime. A positive test, therefore, may only mean that the patient has had lymphogranuloma venereum at some time in the past, rather than his present symptoms being caused by this disease. False positive Frei reactions may occur in other related virus infections.

(2) A diagnosis of lymphogranuloma venereum should not be made on the basis of a positive Frei reaction in the absence of clinical signs.

(3) A negative Frei reaction in the presence of a clinically suspicious lesion of at least three weeks' duration is of value in excluding the diagnosis of lymphogranuloma venereum.

(4) The complement fixation test for lymphogranuloma venereum is no longer in the experimental stage, but is still not available for general use.

e. Differential Diagnosis

(1) Lymphogranuloma venereum must be differentiated from malignant tumors, Hodgkin's disease, tularemia, amebic proctitis, tuberculosis, meningoencephalitis, pyogenic infections, plague, chancroidal bubo, granuloma inguinale, and syphilis. Syphilis should be ruled out by dark field examinations of material from genital lesions or regional lymph nodes and by serologic examination which should be repeated monthly for at least three months. Low titre positive serologic tests for syphilis may occur in this disease.

f. Treatment

(1) Local. The fluctuant nodes may be aspirated; but incision and drainage should not be used. Radical excision is inadvisable because of the risk of lymphatic obstruction and chronic swelling of the penis, scrotum, or vulva.

(2) Chemotherapy. Sulfadiazine should be administered in a dose of 1 gram three times daily for 21 days.

(3) Surgical. Patients with late complications who do not respond to sulfonamide therapy, should be handled in the following manner:

(a) Rectal Stricture. Prolonged gentle dilatation, preferably manual. Colostomy should not be performed unless dilation is impossible, because of location of the stricture, or has failed.

(b) Peri-rectal abscess. Surgical incision and drainage.

(c) Fistula-in-ano. Should be excised where possible.

14. Granuloma Inguinale

a. Definition

(1) Granuloma inguinale is a chronic disease due to infection with a Donovan body, which is possibly of bacterial nature. It is a mildly contagious, progressive disease, characterized by a sharply defined, granulomatous, usually painless, initial lesion, involving the skin of the genital or inguinal region, and spreading gradually by continuity or contiguity. Rarely, it is a systemic disease involving bones, joints, and viscera. Granuloma inguinale is a distinct disease entity and should not be confused with lymphogranuloma venereum.

b. Epidemiology

(1) Some doubt exists concerning the manner of spread of granuloma inguinale. The consensus is that it is venereally acquired and that its communicability is low. There appears to be marked differences in racial and individual susceptibility.

c. Course

(1) The disease starts as a vesicle, papule or nodule. The surface epithelium becomes excoriated or eroded, leaving an ulcer with a beefy red granular base. An early lesion may be a clean, raised, velvety, smooth tuft of granulation

tissue, situated at the mucocutaneous border of the vaginal orifice, at the preputial orifice, or on the glans or inner surface of the prepuce. The margin of the lesion is sharply defined. The granulation tissue, if traumatized, bleeds easily. The lesions are not painful unless grossly secondarily infected. There is very little tendency to spontaneous healing. The lesions spread by continuity or contiguity. Extension is often slow. There is a predilection for moist contact surfaces, particularly in the cruroscrotal folds, the groins, and the cleft and folds of the buttocks. The advancing border of the lesion has characteristic rolled edges, the granulation tissue piling over onto the bordering epithelial surface.

(2) The ulcerative process may remain more or less stationary for many years. Secondary elephantoid enlargement of penis, scrotum, or labia may occur. The lesions may heal with scar formation at one margin and progress at another. There are three types of lesions: exuberant, ulcerative and cicatricial.

(3) Ultimately, marked impairment of general health may occur, ending in extreme cachexia and death.

d. Diagnosis

(1) The clinical appearance of a chronic ulcerative process involving the skin of the groin and genital areas, without involvement of the lymph nodes, is characteristic of the disease. The demonstration of Donovan bodies confirms the diagnosis.

(2) For this demonstration spreads should be made from scrapings or punch biopsy of clean granulation tissue, and stained by Wright or Giemsa stain. Histologic study of tissue sections taken by biopsy from a peripheral area of diseased tissue may demonstrate the pathognomonic large cells with cystic spaces containing Donovan bodies.

(3) Lymphogranuloma venereum, chancroid, carcinoma and syphilis should be considered in the differential diagnosis, and appropriate diagnostic tests should be performed. A blood serologic test for syphilis should be made weekly the first month and at monthly intervals for 3 months unless a diagnosis of syphilis is established earlier.

e. Treatment

(1) Fuadin (a complex antimony compound). This drug is also known as neoantimosan and stibophen. It is supplied in ampules containing 6.4 percent solution (0.064 gm fuadin, 1 grain, in 1 cc). Fuadin solution is given intramuscularly. The first three doses of 1.5 cc, 3.5 cc, and 5 cc are given on successive days, followed by 5 cc two or three times weekly until complete healing has taken place; and, in order to prevent relapse, continued at weekly intervals for 6 months after complete healing. The most commonly reported toxic symptom is vomiting. Rarely, joint and muscle pains may appear. If any toxic symptom occurs, the dose should be reduced.

(2) Antimony and potassium tartrate (tartar emetic). If there is no response to fuadin therapy after 6 weeks of treatment, antimony and potassium tartrate should be administered. This preparation contains about 36 percent antimony. One percent solution should be freshly prepared using supplies of sterile

distilled water or physiological saline. The solution should be perfectly clear and free from sediment. It is sterilized by gentle boiling for 5 minutes. Solution should not be autoclaved. The drug is best tolerated 2 to 3 hours after a light meal. It is administered intravenously and should be given slowly. Since the solution is very irritating, the needle should be wiped off with a sterile sponge and there should be no extravasation. The patient should remain recumbent for at least an hour after treatment. The first dose is 3 cc (0.03 gm tartrate). Provided no untoward reaction occurs, subsequent doses are given on alternate days and are increased on each occasion by 3 cc (0.03 gm tartrate), until the maximum individual dose of 12 cc (0.12 gm tartrate) is reached. If no toxic reaction appears the maximum tolerated dose may be given 3 times weekly for 15 doses. The toxic effects of antimony and potassium tartrate include coughing immediately upon injection, which is not important; nausea, vomiting, dizziness, and collapse. Transient electrocardiographic changes without corresponding clinical manifestations have been reported. If a toxic reaction other than coughing occurs during administration, the injection should be stopped at once. Following any toxic effect, the subsequent dose or doses should be reduced or omitted according to the circumstances.

(3) Healing under antimony is enhanced by adequate concomitant treatment of gross secondary infection. This may be accomplished by local application of daily wet dressings with weak solutions of potassium permanganate or sodium perborate. Penicillin given intramuscularly every 3 hours, in injections of 10,000 units each, in a total dosage of 400,000 units, is also recommended for the treatment of secondary infection.

(4) X-ray therapy combined with chemotherapy has yielded promising results.

(5) Surgical excision of the entire diseased area may be necessary as a last resort. If used, it must be followed by chemotherapy.

15. Case-Holding and Case-Finding

a. General Considerations

(1) Gonorrhea and syphilis are communicable diseases, and every new patient admitted to a treatment service offers to the personnel a double challenge in case-holding and case-finding. These diseases are communicable, however, under very limited conditions, and their communicability may vary or disappear with the passage of time or with treatment. Both diseases may be clinically asymptomatic and still be communicable or potentially so. Communicable relapse of syphilis and reinfection with gonorrhea are common. An otherwise non-communicable infection with syphilis in a female may become communicable to the infant in pregnancy. Congenital infections are ordinarily communicable only in infancy. Incubation periods are variable and histories of sexual exposure are often indefinite or unreliable. Infectiousness is not easily established by ordinary physical examination; it is likely to be ephemeral, and it is never to be taken lightly since the unexpected may always happen.

(2) Competent medical evaluation of every case is essential to intelligent case-holding and case-finding. It should be obvious, therefore, that those who are to render these services must understand the diseases with which they are to work and must be frequently in consultation with the chief of the treating agency. Reasonably adequate training should be given to all those who are to do this work.

(3) Sympathy, tact, ability to work with patients, and a real interest in venereal disease control are essential in those who are to do case-holding and case-finding. It is important, therefore, that this personnel should be selected with these qualities foremost in mind.

b. Case-Holding

(1) Case-holding is essential if the patient's infection is to be kept under control until it is cured. It is useless, however, to employ a case-holding staff if the fundamental causes of neglect of treatment are ignored. Some of these are failure to explain the disease, its treatment and its communicability to the patient; failure to take the patient's economic problems and job into account; transportation difficulties; rough or discourteous handling of the patient in the clinic; lack of privacy in the clinic; dirty, crowded, unattractive clinic quarters; poor techniques which cause pain, reactions and resentment; inadequate co-operation between related clinic services, the hospital proper, and the venereal disease clinic, so that infections discovered in one service fail to reach the attention of the venereal disease clinic.

(2) An effective case-holding service will be constantly on the watch for neglect on the part of the clinic or other treating agency to cooperate with the patient. It should be the ultimate objective of every case-holding service so completely to solve all of those problems which lead to premature interruption of treatment that only those patients who are mentally unable to cooperate or who are obviously antisocial in their behavior need be referred to the health department for control. Except for the truly noncooperative, every patient which the treating agency finds it necessary to report to the health department for control should be looked upon as a clinic failure in case-holding.

c. Case-Finding

(1) Case-finding is not an objective in itself. If it is to be of any benefit to the community it must lead to one or more of three conclusions; (1) Better information as to the prevalence or incidence of infection in the community, either for the purpose of stimulating support for an improved control program, or as a measure of the effectiveness of a program; (2) The protection of the public health and the promotion of the public safety, as in the discovery of communicable infection or of cardiovascular or neurosyphilis in those who hold lives in their hands and (3) the treatment of the infected.

(2) Mass blood-testing, in some industries for example, is too often used for the purpose of weeding out infected employees who promptly become candidates for discharge from employment. Food-handlers and domestics, in particular, are singled out for blood tests on the completely false premise that infected food-handlers, because of their occupation, are more dangerous than other persons to the public health. These are abuses of a case-finding procedure which protect nobody and which are almost certain, eventually, to bring this case-finding procedure into disrepute.

(3) It is of the utmost importance, therefore, that the health department do all that it can to see to it that any case-finding procedure is used with an intelligent and legitimate objective in mind.

(4) Case-finding procedures may be divided into three main groups: (a) Mass blood testing; (b) direct epidemiologic investigation, starting with a

known infection; and (c) public education, through which those who may have been exposed are encouraged to seek medical advice.

(5) Direct epidemiologic investigation -- Direct epidemiologic investigation, starting with a known infection, is probably the most productive method of case-finding, at least so far as the discovery of communicable infections is concerned. It is when case-finding is initiated by the discovery of a patient with a recently acquired infection that the greatest promise is offered for communicable disease control.

(6) For these reasons, direct epidemiologic investigation is best carried out by representatives of the treating agency, in the name of the treating agency. Only the patient can supply the information by which his contacts may be identified. The clinic follow-up worker has the confidence of the patient and will often be able to obtain the patient's active assistance in bringing the contacts to medical attention. In many cases more than one contact must be investigated although not all of them will be found to be infected. It is much less disturbing to those who must be approached that the approach is made by a representative of a medical agency. There is then an implication of the confidential relationship which is commonly accepted as characteristic of medical agencies. This softens the blow and makes the investigation a medical, rather than a public, and possibly punitive one.

16. Information and Education

a. Professional

(1) Medical - The control of the venereal diseases will depend, in great measure, upon how well the medical profession is informed and trained in the management of these diseases. Whether the physician is engaged in the private practice of medicine, in the treatment of patients in a venereal disease clinic, in medical teaching, or as a health officer, it is he who will make the diagnosis and treat the patient or conceive and direct the control program. It is a matter of fundamental principle, therefore, that the prefectural health department give adequate attention, in the development of its venereal disease program, to the following procedures in medical information and education.

(2) The modification of the curriculum of the medical school toward better instruction in the public health aspects of venereal disease control. The required course should consider general methods and interpretations, control of infectiousness, standard diagnostic and treatment procedures in early and latent syphilis and gonorrhea, the general management of late syphilis, prevention of cardiovascular and congenital syphilis and neuro-syphilis, prevention of the serious complications of gonococcal infection, the use of drugs, and precise instruction in the details of technic with emphasis on indications, reactions and contraindications. Most important of all is the inculcation of modern, sound, basic public health principles. Prefectural health departments have an unusual opportunity, through their close contact with the faculties of medical schools in their prefectures to stimulate medical schools to greater effort and efficiency in teaching venereal disease control.

(3) Postgraduate instruction of practicing physicians. Although this is secondary to better instruction of the medical student, it nonetheless is of great importance. Postgraduate instruction will have to be carried out

locally by meetings of the prefectural medical societies. It will also be carried out on a national basis through the Ministry.

(4) The dissemination of informative literature to private physicians: This is essential. The material used should be so selected that it will aid them in their private practices. It will help to secure their active cooperation in the control program.

(5) Allied professions. Provision should be made, also, for the training and information of nurses, social workers, and public health workers both in training schools and by postgraduate instruction along lines analogous to those followed in the information and training of undergraduate and graduate medical students and practicing physicians. It is from this group that clinic nurses, follow-up workers, health education personnel, and others who will function in one way or another in venereal disease control, will be recruited. It is as important that they, as well as physicians, understand the venereal diseases and control procedures.

b. Public

(1) Intelligent public understanding of the venereal diseases and the objectives of the venereal disease control program is essential to public support of the program and to effective public use of the diagnostic and treatment facilities which are available. It stimulates the activities of the public officials. Effective and persistent public education not only accelerates case-finding and improve case-holding, but it also may be counted upon to inhibit exposure and to encourage prophylaxis against infection.

(2) Virtually all media of public communication -- the press, radio, motion pictures, lectures, publications, exhibits -- are as available and as effective in venereal disease education as in any other field of public health.

(3) Great care should be taken to give the public the unvarnished facts. Over-dramatization should be strictly avoided, for the facts are astonishing enough. Over-dramatization and exaggeration lead, eventually, to loss of public confidence in the health department when the truth becomes known. They also lead to hasty and ill-advised public response. Too many persons will be denied or removed from employment if too much emphasis is placed upon the communicability of the venereal diseases without adequate definition of when and how they are communicable. It is dangerous to put too much emphasis upon the blood test as an end in itself. It should be made clear that a blood test should form part of every general physical examination, or that a careful examination, including a blood test, should be made if there may have been exposure to an infection.

(4) Ambiguity and statements which may be misinterpreted should be avoided. Statistics should not be complicated, or require interpretations of which the audience to be reached is incapable. They should be adjusted to the conditions in the area to be reached. Statistics which describe conditions which exist in one part of the country may not be at all applicable to conditions in other areas. If data are used which represent average conditions over the country at large, it should be made clear that they are average, and how they correspond with the local situation.

c. Patient Education

(1) Physicians in charge of venereal disease clinics as well as private physicians doing venereal disease work have a professional obligation to provide venereal disease patients with the basic facts about these diseases, how they are contracted, diagnosed and treated, and how they may be avoided and kept from spreading.

(2) Contact tracing and the prevention of re-infection will be greatly facilitated by realistic and intelligently applied patient education. All members of the clinic staff who come into contact with patients or suspects must be thoroughly trained in the essential facts of venereal disease diagnosis, treatment, epidemiology and prevention.

17. The Charlatan, and The Unethical Pharmacist and Physician

a. It is known that a large number of people are treated, or drugs are prescribed and dispensed for their infections, by unethical drug clerks. Charlatans and unethical physicians, also, treat many patients, especially in the larger cities. Since none of these is trained in the diagnosis or treatment of the venereal diseases or competent or equipped to evaluate a cure, every effort should be made to protect the infected from this dangerous exploitation.

b. When legislation has been enacted, the health department should make such observations as may be necessary to see that it is observed, and should report any violations to the proper enforcement authority. It may be necessary in some cases to send health department inspectors to certain drug stores to discover whether the law is being obeyed.

c. The Charlatan usually violates medical practice laws already in existence. His control is a matter of law enforcement rather than of the enactment of new legislation. The function of the health department in the control of the charlatan is to call him to the attention of the proper enforcement agency whenever it can be discovered that he is practicing in the community.

d. The control of the unethical physician is a problem for the medical profession. What may be considered as unethical practice is often a matter of degree of mismanagement. The old-fashioned "clap-doctor" does not bother with the refinements of correct diagnosis. He treats the patient as long as payments are forthcoming or for a specified period for a specified sum, often payable in advance. He is more interested in what he can collect than in the excellence of his management of the disease, although he must enjoy a certain amount of success in symptomatic cure at least, to acquire his large clientele. In the long run, however, except that he bleeds the patient financially, he probably is no more dangerous to the public health than the physician who uses legitimate treatment procedures unintelligently and who is satisfied with symptomatic cure. The problem is largely one of convincing all physicians that if they are to treat venereal disease at all, they should know what they are doing and should treat and evaluate cure according to the best methods available.

e. The protection of the public against the exploitation of all three, charlatan and unethical or careless physician and drug clerk, may be advanced, also, through public health education. If the public becomes adequately informed as to the proper methods to be used in the diagnosis, treatment, and determination

of cure of the venereal diseases, the infected may be better able to determine at once whether they are in the hands of a physician who knows what he is doing. It should be the constant effort, therefore, of every health department to inform the public as rapidly as possible upon these matters. Every patient seen by an ethical treatment source should be thoroughly instructed in the difference between good and poor management of venereal infections, for informed and well-treated patients make excellent salesmen among their infected friends.

18. Prostitution

a. The economic, political and social aspects of prostitution are well known. Prostitution is largely a Social Welfare problem for all of society. Actually, only the infectious disease aspects of prostitution are medical, although as good citizens, doctors must admit that prostitution, in addition to being medically harmful, is also ethically and socially wrong.

b. It is well known that prostitutes are recruited almost entirely from the lowest economic levels of society. They are mainly daughters of homes where there has been too little food, too little clothing, inadequate shelter, insufficient forms of decent recreation, and too little opportunity to acquire an average education. In short these women have had too little of all the good things of life. In addition they usually come from homes where there has been marital discord, homes that have been broken up, or where as children, they received insufficient parental affection and guidance.

c. While we pity any woman who must earn her living in this manner, we must realize that prostitution is an antisocial, even if a still legal pursuit in Japan. It cannot be considered an honorable or responsible occupation for a woman. The fact that certain women are prostitutes, lowers the status of all women. No little girl grows up with the ideal of becoming a prostitute. It is a last choice occupation.

d. Prostitution should not be dignified with the term "Profession", or some euphemistic term like "Angels of the Night". It is actually an antisocial sweated occupation which does more damage to more people and is of greater cost to all society than the occasional burglar or other criminal. Such organizations as "prostitute unions" or "mutual benefit associations", are really a mark of shame and disrespect to unions of honest workers who are doing socially useful work in their communities.

e. No democratic country must find the solution to its economic problems at the expense of its poorest people. The question of how these women are going to live is an economic and social welfare problem, not a medical one. They cannot be permitted to infect the entire population just so they can live, any more than society could allow other antisocial individuals to operate at the expense of the welfare of society. Therefore, while we may be sympathetic with the plight of all people in low economic levels, we cannot permit any of them to operate at the expense of society, because they endanger the health and welfare of the community.

f. It is understood that the main individuals at fault are the owners and managers of brothels, and patrons of prostitutes. In every country there are always disreputable characters who will try every device, if they see the opportunity to make money at it, even though society may suffer. Whenever these

individuals crop up, society has to see that they are put down. Commercial prostitution must be made unprofitable. Prostitutes, since they do endanger the community, must be detained, reoriented, reeducated, taught useful occupations and treated medically to cure their diseases.

g. It has been firmly established throughout the world that, given the opportunity, most prostitutes are amenable to reorientation and rehabilitation and can become socially acceptable members of modern society.

h. Failure to control the sources of infection in any campaign against the venereal diseases, favors the spread of these diseases. It is known that many persons who are infected with gonorrhea, syphilis and chancroid acquire their infections from prostitutes or from persons who have been infected by those practicing prostitution.

i. It is generally accepted that the licensing or toleration of prostitution and of agencies promoting prostitution, or the segregation of prostitutes in special areas, increased the opportunities and accessibility of prostitutes and the volume of their promiscuity. The streetwalker who must hunt for each patron can only infect about three or four individuals a night, while the prostitute in a brothel can easily infect thirty or forty individuals.

j. No health department should ever engage in the medical supervision of prostitutes. If it does, it is open to criticism medically, and for becoming a supervisory partner in an anti-social, commercial venture. If brothel owners feel it would be beneficial for their business to have their employees examined at intervals, it is purely a commercial device without medical basis. Any honest medical study on these prostitutes would leave the brothel keeper with no prostitutes to carry on his business. As was said by a French medical officer in a position of great responsibility, speaking of routine examinations of prostitutes, "If the doctor is good, the system is bad; if the doctor is poor, the system is dreadful; and we know what kind of doctors make their living off prostitutes". No health department physician should be placed in this category.

k. Infection is too difficult to detect by any system of routine examination, and exposure between examinations is too frequent to make the procedure effective. No epidemiologic procedure in the hands of the health officer can solve this problem. Even when it is possible to trace an infection to a particular girl in a specific house, the incubation period (of syphilis at least) is so long that many infections will have been caused by a busy prostitute before the health officer can even start the epidemiologic process. Prostitutes often may show improvement under present treatment, but they will still be infectious when they return to their occupation.

l. An observation and isolation period of at least six weeks, during which time additional clinical and laboratory examinations are made, is necessary before a patient can be said to be probably free from venereal disease infections. Even then the clinician cannot be certain of his diagnosis. Periodic examinations alone as a means of reducing the infectivity of promiscuous persons are known to be medically useless. Such procedures give a false sense of security to the public and further indoctrinate them with the fallacious idea that prostitutes are the only ones who have venereal diseases.

m. The routine periodic examination of prostitutes cannot be recommended, but as long as health departments in Japan still engage in this practice, they should be aware of the following factors:

(1) Periodic examinations of prostitutes as a means of controlling venereal disease has long been known to be medically worthless and utterly futile. This is the opinion of the world's best university and Public Health Physicians.

(2) The enormous amount of venereal disease in Japan today is the best proof of the failure of this system.

(3) No epidemiologic or clinical procedure in the hands of any health officer can control the infectious spread into the community by prostitutes

(4) Prostitution cannot be controlled by medical means alone. It is the duty of the health officer to show the public that the suppression of prostitution is a function of the police and courts. To do this, the police and courts have to work on the basis of a law which prohibits prostitution and its allied activities, that is, owning or managing brothels, procuring, and even those patronizing brothels.

(5) Wherever routine examinations of prostitutes are done it will be found that a low professional level exists. Good physicians will not do this work, knowing its uselessness and the corruption that invariably creeps in.

(6) Health departments who do this work are obvious examples of deterioration and degeneration.

(7) Such health departments can be seen to do nothing for the public, but end by devoting their entire attention to a small segment of the population--the prostitutes, who are actually some brothel keepers private employees.

(8) In view of the lack of funds, facilities, and supplies it is difficult to justify useless work on prostitutes, when useful work could be done on the general population who have a greater chance to stay cured once they are properly treated.

(9) More reasons for not engaging in this work could be given, a partial list is as follows:

(a) The Health department becomes a supervisory partner in an antisocial, commercial venture.

(b) It fosters the idea that prostitution is approved by the Health Department.

(c) It continues the erroneous notion that prostitutes can be kept from infecting their patrons by any system of medical examinations.

(d) It encourages use of brothels.

(e) It focuses attention on the erroneous idea that only prostitutes have venereal disease.

(f) Infection is often too difficult to detect in a single examination.

(g) Prostitutes use various measures to escape detection (urinating, douches, sulfonamides).

(h) Laboratory tests are partially dependent on the proper collection of material by the clinician. In chronic gonorrhea the organisms are deep in the smaller mucus glands, and if this material is not expressed, the smears will be useless.

(i) Some laboratory tests are inconclusive. Smears and cultures are not reliable in chronic gonorrheal endocervicitis.

(j) Laboratory tests are not infallible, but only as good as the person doing the test.

(k) Some laboratory tests take more than one day to perform.

(l) Laboratory tests may be negative during the incubation period of the disease.

(m) In syphilis the incubation period may be as long as six or eight weeks.

(n) If the primary lesion is small and not detected, twelve weeks may elapse before secondary signs appear.

(o) A busy prostitute could be theoretically free from disease when examined, become infected by her first patron, and thereafter infect most of the succeeding customers until the next examination -- if she is not overlooked at this time.

(p) Repeated studies on unselected groups of prostitutes have shown from 50% - 90% to be infected with one or more venereal diseases.

(q) Any routine examination which fails to find infections in one-half to nine-tenths of the examinees therefore is missing many infections and allowing them to return to infect more people.

(r) Routine examinations and treatment of prostitutes is therefore non-productive work. Even the few who are diagnosed and treated soon become reinfected. The main accomplishment is probably a penal job of keeping the prostitute from infecting others during the period of isolation.

n. Every health department must make clear the distinction between its function and that of the police department. Law enforcement is a police problem and not a function of the health department. The police apprehend law breakers or suspects, the health department uses persuasion and voluntary methods to encourage the attendance of persons possibly infected with diseases. While the health department is responsible for controlling all the infections it is possible to trace through epidemiologic processes, it is most unreasonable to make the health department solely responsible for the control of the sources of disease, and then to express surprise and indignation upon discovering that the health

department, working alone, has been unable to do much about putting the owners and managers of brothels and the procurers out of business.

o. The police and court authorities are responsible for the enforcement of whatever laws exist regarding prostitution. Health departments will cooperate with the above branches of government in the carrying out of the medical aspects of these laws. That is to say public health agencies will examine, diagnose and treat persons apprehended by the police as well as all individuals who apply voluntarily for service. The apprehension or sentencing of persons who break the laws is not the concern of the health department. The nature of the punishment should be determined without consideration of the element of infection.

p. Little will be accomplished so long as the health officer remains the only stimulus to police activity. When the police are required by law to take effective action, they will attack the problem from the direction of ridding the community of all infectious persons whether on the streets or in brothels. It is a function of the health officer to persuade the public that this is a police problem and not one of epidemiology to any practical extent. If the health department allows itself or is forced to take over the function of the police, it will degenerate eventually into the same "protective" agency that the police in some places are alleged to have become.

q. The Venereal Disease Control program should be redirected to the finding and treating of these diseases in the general population. All members of society including prostitutes, waitresses, hostesses, dance hall girls, etc., will be gladly accepted for diagnostic and treatment services, as individuals. However, routine examinations of any special groups are not done by public agencies in countries where there are modern venereal disease control programs.

19. Classification of the Venereal Diseases

a. Syphilis

(1) Primary - (chancre present)

(a) Dark field positive Sero Negative

(b) Dark field negative Sero Positive

(c) Dark field positive Sero Positive

(2) Secondary - (skin eruption, mucus patches, condylomata lata, patchy alopecias, generalized adenopathy, arthralgia, iritis, may all be present either in combinations or alone). The blood test is always positive.

(3) Early Latent (No objective signs or symptoms, Cerebrospinal fluid negative, within 4 years of the initial infection, serology is positive).

(4) Late Latent Syphilis (Same criteria as above but of more than 4 years duration).

(5) Late Syphilis (State type, Example: C.N.S. Cardiovascular, Bone, Cutaneous, other Visceral).

(6) Congenital

b. Gonorrhea

- (1) Acute - duration less than 3 months
- (2) Chronic - duration more than 3 months
- (3) Ophthalmia

c. Chancroid

d. Lymphogranuloma Venereum

e. Granuloma Inguinale

20. Community Venereal Disease Control Councils

In order to bring about the public action necessary to develop and maintain effective local conditions and practices in support of the medical control program, committees must often be mobilized and organized. There were in previous years several organized groups in Japan who were interested in venereal disease control. Remnants of these groups may still exist. However, in many areas there were no such groups, and it will be necessary to organize them from the beginning. It will be helpful in the solving of all public health problems if committees of laymen are organized to study ways and methods for the community to act on these matters. In some places these groups may be limited to a city or village. In other areas there may be one group for the entire prefecture.

In the absence of any existing organization of the general public to study and act upon community venereal disease control problems, the following procedure is recommended:

a. Under the auspices of a few civic minded individuals or groups, call together representatives of the following groups: School system, labor union organization, local government, newspapers, welfare agencies, church groups, medical society, law enforcement agency, and any other groups who should be interested within this field, members of professional and business groups.

b. Representatives of these groups, meeting with the prefectural venereal disease control officer, present and discuss the local venereal disease problems. The group is then asked to cooperate in planning a solution for this problem.

c. A small executive committee should be chosen, and to encourage continuous interest in their activity, it has been found useful to break the larger group into the following sections: Law enforcement, social welfare, health education and information, medical services and group participation.

The prefectural venereal disease control officer uses these sections to improve control work in these fields, especially in health education and information. He is present so that the community representatives can make him aware and keep him cognizant of the public demands and possible need for extension of venereal disease control facilities. No community action campaign is successful in the long run, unless it reaches and motivates the average man, or woman. It is his health with which we are concerned and his cooperation obviously should be secured. Education alone will not suffice, active public participation is required.

CLINIC MONTHLY REPORT

CLINIC _____

PREFECTURE _____

FOR THE MONTH OF _____ 19____

CITY, TOWN OR VILLAGE _____

PATIENT LOAD		SYPHILIS						GONORRHEA		CHAN-CROID	ALL OTHER VENEREAL DISEASES
		PRI-MARY	SECOND-ARY	EARLY LATENT	LATE LATENT	LATE	CONGEN-ITAL	ACUTE	CHRONIC		
1. CASES CARRIED OVER FROM PREVIOUS MONTH	MALE										
	FEMALE GROUP A*										
	FEMALE OTHERS										
	TOTAL										
2. NEW CASES* PREVIOUSLY TREATED BY THIS OR ANY OTHER CLINIC OR PRIVATE PHYSICIAN	MALE										
	FEMALE GROUP A*										
	FEMALE OTHERS										
	TOTAL										
3. READMISSIONS AND CASES PREVIOUSLY TREATED BY ANY OTHER CLINIC OR PRIVATE PHYSICIAN, BUT NEW TO THIS CLINIC	MALE										
	FEMALE GROUP A*										
	FEMALE OTHERS										
	TOTAL										
4. CASES DISCHARGED AS CURED DURING MONTH	MALE										
	FEMALE GROUP A*										
	FEMALE OTHERS										
	TOTAL										
5. CASES REFERRED TO OTHER CARE	MALE										
	FEMALE GROUP A*										
	FEMALE OTHERS										
	TOTAL										
6. CASES THAT DISCONTINUED TREATMENT WITHOUT PERMISSION THE ENTIRE MONTH	MALE										
	FEMALE GROUP A*										
	FEMALE OTHERS										
	TOTAL										
7. TOTAL PATIENT LOAD AT END OF MONTH <small>ITEM (1+2+3) MINUS (4+5+6)</small>	MALE										
	FEMALE GROUP A*										
	FEMALE OTHERS										
	TOTAL										
8. NUMBER OF PERSONS EXAMINED AND FOUND	POSITIVE MALE										
	POSITIVE FEMALE										
	NEGATIVE MALE										
	NEGATIVE FEMALE										
TOTAL											
9. NUMBER OF INJECTIONS AND TREATMENTS	INJECTIONS OF						TREATMENTS				
	ARSENICALS		BISMUTH		PENICILLIN						
	MALE										
	FEMALE										
TOTAL											
10. NUMBER OF LABORATORY TESTS	SEROLOGIC TESTS		DARK FIELD EXAMINATIONS		ALL KINDS OF TESTS						
	BLOOD		SPINAL FLUID								
	POSITIVE										
	NEGATIVE										
TOTAL											
11. CONTACTS	NUMBER REPORTED										
	NUMBER EXAMINED, FOUND INFECTED										
	NUMBER EXAMINED, NOT INFECTED										
	NUMBER OF VISITS FOR CONTACT TRACING				returned						
12. TOTAL NUMBER OF VISITS TO CLINIC FOR TREATMENT, OBSERVATION OR ADVICE BY ALL PATIENTS FOR ALL VENEREAL DISEASES											
13. NUMBER OF VISITS FOR DELINQUENT CASES				14. NUMBER OF DELINQUENT PATIENT TO TREATMENT				15. TOTAL LAPSED CASES ALL V.D.			
16. CASE FINDING FOR ALL V.D.	VOLUNTARY	REFERRED BY PRIVATE PHYSICIAN	BROUGHT BY POLICE	REFERRED BY PUBLIC CLINIC	BY CONTACT TRACING	COMPULSORY PROSTITUTE EXAMINATION	ALL OTHERS				

DATE _____, 19____

SUBMITTED BY _____

TITLE _____

ALL CLINICS TREATING VENEREAL DISEASES REQUIRED TO SUBMIT THIS FORM IN DUPLICATE BY 5TH DAY OF EACH SUCCEEDING MONTH
* GROUP A INCLUDES PROSTITUTES IN BROTHELS, STREET WALKERS AND ALL OTHER PROSTITUTES

